CHAPTER 8
SECTION 9

CLAIMCHECK

1.0. REBUNDLING OF PROCEDURES - CLAIMS SUBJECT TO CLAIMCHECK

TRICARE does not allow a separate payment for procedures that are component parts of a more comprehensive group of services performed at the same time. When component parts are billed separately, i.e., unbundled or fragmented, the allowable amount for the more comprehensive procedure is to be used in determining reimbursement and the unbundled procedures disallowed as being covered by the amount allowed for the comprehensive procedure. Refer to the Policy Manual, Chapter 13, Section 1.4 and Chapter 11, Section 14.1.

2.0. ALLOWABLE CHARGE REVIEWS

Beneficiaries and participating providers have the right to request a review of the amount allowed for rebundled claims. The disallowance of unbundled procedures is an allowable charge issue and is not appealable. The procedures in the Chapter 12, Section 9, apply for these reviews the same as for any other type of allowable charge reduction.

3.0. POSTIMPLEMENTATION PROVIDER NOTIFICATION

Contractors shall establish procedures for detecting providers who submit fragmented claims to monitor billing practices and focus on providers with egregious patterns. Reports are to be produced at least quarterly which identify these providers and the fragmented codes billed for educational contacts by professional relations staff. These contacts are to be documented. Contractors are to advise providers that unbundled billings are in violation of acceptable billing practices and repeated occurrences may be considered potential fraud or program abuse in accordance with 32 CFR 199.9. Contractors shall refer non-compliant providers to their program integrity unit no later than the third occurrence following the initial educational contact and issue written notice that exclusion from the program can result if unbundled billings continue.

4.0. PROCEDURE CODE ACCURACY

To assist procedure coding accuracy, consistency, and reliability at the claim entry level for the procedure code rebundling edits, contractors shall install an automated encoding capability. A functional capability equivalent to that available with the GMIS software product called Autocoder is recommended.

5.0. HCSR REPORTING REQUIREMENTS

5.1. Procedures bundled into another billed procedure code. When certain billed procedure codes are denied and bundled to a more appropriate code that also has been

billed, the bundled line items for which no allowable amount applies are to be denied and reported on the HCSR using Denial Reason Code "GG".

EXAMPLE: Procedures A and B are billed at $100.00 each. TRICARE Claimcheck rebundles procedure A into procedure B which is a more comprehensive procedure code and reflects the more appropriate billing of procedures A and B.

CODE	BILLED	STATUS
A	$100.00	Denial Reason Code "GG"
B	$100.00	$100.00 (New Pricing Code "F" - "O")

Both procedures A and B are billed on the claim. Procedure A is denied using Denial Reason Code "GG".

5.2. Procedures bundled into an unbilled procedure code (TRICARE Claimcheck inserted procedure code). When TRICARE Claimcheck inserts a procedure code that has not been billed on the claim and rebundles the billed procedures into that code, the following reporting requirements apply. The bundled, billed procedures are to be deleted and the TRICARE Claimcheck inserted procedure code is to be reported on the HCSR using the appropriate Pricing Code (codes "F" through "O" that are TRICARE Claimcheck-specific).

EXAMPLE: Procedures A and B are billed at $100.00 each. TRICARE Claimcheck inserts a third code to the claim, procedure C, which reflects the more appropriate billing of procedures A and B.

CODE	BILLED	STATUS
A		Deleted
B		Deleted
C	$200.00	$100.00 (New Pricing Code "F" - "O")

Procedures A and B are deleted and procedure C (which was not actually billed on the claim but was inserted by TRICARE Claimcheck) is reported using the appropriate Pricing Code (codes "F" through "O").

5.3. Procedures identified as mutually exclusive, incidental, or an unnecessary assistant surgeon by TRICARE Claimcheck. When TRICARE Claimcheck denies any billed procedure, that procedure is to be reported on the HCSR using Denial Reason Code "GG".

6.0. EOB MESSAGE REQUIREMENTS

6.1. An appropriate EOB message is to be reported on EOBs for the disallowed component procedures, whether submitted on the same claim with the comprehensive procedure or on a separate claim:

6.2. An appropriate EOB message is to be reported for comprehensive procedures for which the allowable amount is reduced due to payment of the component procedure(s) on a previous claim.

7.0. QUARTERLY REBUNDLING SUMMARY REPORT

Contractors shall submit rebundling summary reports in the format specified at Chapter 8, Addendum A, Figure 8-A-11 to TMA, Managed Care Support Office beginning with the first quarter after implementation of TRICARE Claimcheck. By the end of the month after each quarter, Contractors are to submit to TMA a report by contract area which provides the following information for the report quarter:

7.1. The number of unduplicated providers (participating and non-participating) having billings which failed any of the rebundling edits, regardless of whether on single or multiple claims.

7.2. The number of times the edits were invoked.

7.3. The total billed amount for the edited procedures (both Column One and Column Two procedures).

7.4. The total allowed amount for the rebundled procedures.

7.5. The total dollar savings which is defined as the difference between the otherwise allowable amount (lower of prevailing or billed) for the unbundled procedures billed and the amount allowed as a result of rebundling.